

Vermont Emergency Medical Services  
108 Cherry St., P.O. Box 70  
Burlington, VT 05402  
(802) 863-7310 or 1-800-244-0911

**Request For EMS Examination**

**PLEASE READ THE INSTRUCTIONS ON THE REVERSE SIDE BEFORE COMPLETING THIS FORM**

**Exam Logistics**

Written Exam: Date \_\_\_\_\_ Time \_\_\_\_\_ Location: \_\_\_\_\_ Course # \_\_\_\_\_

Practical Exam: Date \_\_\_\_\_ Time \_\_\_\_\_ Location: \_\_\_\_\_

**How many candidates can the test site accommodate at each level?**

	<u>Written</u>	<u>Practical</u>		<u>Written</u>	<u>Practical</u>
FRECA Initial	_____	_____	EMT-B Recertification	_____	_____
FRECA Recertification*	_____	_____	EMT-Intermediate-90	_____	_____
ECA Transition Part #2	_____	_____	EMT-Intermediate-03	_____	_____
EMT-B Initial	_____	_____	EMT-I-03 Transition	_____	_____
FR to EMT Mod. # _____	_____	_____			

\* Also used for Part #1 of the ECA to FRECA + 4 Transition

**How many candidates will test at each of the following practical stations?**

FRECA (initial, recert & trans):	_____ Trauma	_____ CPR	_____ Airway	_____ Bleeding Control
EMT-Basic Initial:	_____ Trauma	_____ Medical	_____ AED/CPR	_____ Spinal _____ Random
EMT-B Recertification:	_____ Trauma	_____ Medical	_____ AED/CPR	
EMT-I-90:	_____ Pt. Assessmt.	_____ Airway	_____ IV/Meds Administration	
EMT-I-03:	_____ Pt. Assessmt.	_____ Airway	_____ IV/Meds Administration	
I-03 Transition:	_____ AMS	_____ Diff Breath	_____ Chest Pain	

**Exam Coordinator (Proctor)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**Cannot be a Post Office Box**

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

I agree to conduct this examination in accordance with the laws, rules and policies (including the Examination Coordinator's Manual as appropriate) of the Vermont Department of Health and the National Registry, as appropriate. If this request is for a Modules, ECA Transition or EMT-I-03 Transition exam, I have read and signed the attached **security agreement** stating that I understand my role and responsibilities as the exam proctor.

Exam Coordinator Signature \_\_\_\_\_ Date \_\_\_\_\_

**Local Approval**

EMS District # \_\_\_\_\_ requests that the Vermont Department of Health sanction the examination described above. The District Board understands that a district is allowed one examination requiring a state proctor with fewer than 25 candidates each fiscal year (July 1 – June 30). This examination (circle one) **IS / IS NOT** such an examination.

☐ District Chairperson Signature \_\_\_\_\_ Date \_\_\_\_\_

☐ District Training Coordinator Signature \_\_\_\_\_ Date \_\_\_\_\_

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**BELOW IS FOR OFFICE USE ONLY**

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Date received \_\_\_\_\_ Approved \_\_\_\_\_ Disapproved \_\_\_\_\_

VT EMS Signature \_\_\_\_\_ Staff \_\_\_\_\_ Course # \_\_\_\_\_

## **Request for EMS Examination INSTRUCTIONS**

### **Exam Logistics**

Enter the date, starting time and specific location of the written and practical exams, including a room number if applicable. Ordinarily, the written exam takes place first, followed by the practical. If you anticipate a different arrangement, please describe it in the Notes section below.

### **How many candidates can your test site accommodate?**

Fill in the number of candidates you expect to be testing for each certification level. If you can accommodate additional candidates, please include them in this number.

### **How many candidates will test at each of the following practical stations?**

Fill in the number of candidates you expect to have for each practical station, based on the number of candidates and the testing resources you will have available. If you can accommodate additional candidates, please include them in this number.

### **Exam Coordinator**

Fill in the name and address of the person who will take responsibility for running the exam. Also fill in the coordinator's preferred phone and/or email contact information. The exam coordinator must sign and date this portion of the application. **If the Exam Coordinator will be receiving test materials from the EMS Office, he or she must provide a street address (not a PO Box), and it must not be an ambulance or first responder service address.**

### **Local Approval**

Your EMS District Board must request that the Vermont Department of Health sanction the exam. Please indicate the district number and whether this exam will be the district's one exam proctored by state personnel this fiscal year with fewer than 25 candidates. The District Chair or District Training Coordinator must sign and date this portion of the application.

### **EMS Office Approval**

The EMS Office will review this application and fill out the bottom portion. A copy of the application will be sent to the exam coordinator indicating whether or not the exam has been approved.

NOTES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_